SAFER SEX GUIDELINES

A RESOURCE DOCUMENT FOR EDUCATORS AND COUNSELLORS

CANADIAN AIDS SOCIETY

SOCIÉTÉ CANADIENNE DU SIDA

SAFER SEX GUIDELINES:

A RESOURCE DOCUMENT FOR EDUCATORS AND COUNSELLORS

REPORT FROM

THE CANADIAN AIDS SOCIETY

CONSULTATION ON SAFER SEX

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Preface

The Canadian AIDS Society: Who are we?

In July 1985, a gathering of frontline AIDS workers across the country gave birth to the **Canadian AIDS Society**. They saw a need for a national coalition with a national voice.

Three years later, with headquarters in Ottawa, the Canadian AIDS Society represents thirty organizations, in which men and women provide the bulk of education, support and advocacy for people affected by the AIDS crisis.

Our members are volunteer-based community groups. From the Atlantic to the Pacific, on the Prairies, in Quebec and Ontario, our organizations are working together to create a just and effective response to AIDS in Canada. Their national coalition, the Canadian AIDS Society, provides them with a national voice.

The men and women of our organizations identified the need for common standard for safer sex education and counselling. The Canadian AIDS Society decided to provide this standard in order to support the complex and necessary work of promoting safer sex. It is a primary line of prevention.

The **Safer Sex Guidelines** presented here as a resource document for educators and counsellors, are a concrete response to a concrete need. This is the hallmark of the community-based response.

The Guidelines are based on educational needs and on the best scientific information available to us. We fully expect that they will require revision in light of new developments. We ask those who use this document to share your comments with us so that future editions will improve its usefulness.

Please write to us with your comments and suggestions.

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1.0 Introduction

1.01 A Canadian AIDS Society Perspective On AIDS: Affirming Sexuality And Health

The twin problems of indifference and panic in the face of HIV infection influence our agenda for safer sex education and counselling. It is common for human beings to deny the approach of danger when its presence is too threatening to recognize. Catastrophes are typically misfortunes that happen to the "others", not me or mine. Men and women who work to prevent the further spread of this tragic infection must look for ways to catch the attention of people whose futures may be in grave danger, but whose defence mechanisms have outlived their usefulness. We have to reach the consciousness of everyone who is at risk of HIV infection, helping to replace self-deception and apathy with a sense of the urgency of a safer sexual life.

Other people sense too well the approach of danger and feel overwhelmed by it. For them, knowledge provokes a powerlessness that may lead to either self-destructive inactivity or a despairing celebration of the last days before the end. Education and counselling must enable people to confront AIDS, and to use knowledge and a supportive environment in order to change, for the sake of their lives and their sexuality.

The Canadian AIDS Society affirms both sexuality and health as possible and compatible. Some accounts of the present crisis contain a barely concealed satisfaction at the ravages which this virus has brought to the lives of men and women of whom they do not approve. Others, wounded by the loss of loved ones and victimized by deeply inculcated values that have betrayed them, surrender to fear. From both sides we hear the phrase, "The party's over."

Sexuality for humans is a source of pleasure, playfulness, adventure, bonding and generativity. We do not believe it to be a grim business, but neither does calling sexual expression "a party" do it justice. A party, however enjoyable, is a parenthesis in life. Sexuality overflows the bounds of parentheses. AIDS is not caused by sex but by a virus. We aim for a new sexual culture where health and sex can both be celebrated.

This is not an easy task. The obstacles are psychological as much as epidemiological. We offer this report to the member organizations of the Canadian AIDS Society to support their daily struggles to prevent the spread of HIV and to empower women and men to take responsibility for their lives in face of a massive challenge.

We offer it as well to people in Canada and elsewhere whose professions or involvements draw them into the effort to support both human sexuality and health.

1.02 Safer Sex Guidelines: The Problems

The emergence of AIDS and other forms of HIV (Human Immuno-deficiency Virus) infection onto the North American scene in the last several years has created much controversy. In the absence of an effective vaccine, the only preventive measures that society has been able to institute have been educational efforts aimed at promoting "safer sex". Uneasy at the prospect of giving the simplistic impression that most sexual activity was either completely safe or completely unsafe, educators and counsellors in the field abandoned the term "safe sex" in favor of the more accurate "safer sex." Despite the desire for unambiguous and authoritative direction on the part of many, the variable levels of efficiency of HIV transmission associated with different sexual activities or groups of activities has created areas of uncertainty.

The admission of uncertainty on the part of AIDS educators and counsellors, while ethically right, has made the task of prevention more complex. In addition, there appears to be quite a considerable variation in the kinds of advice given from different quarters. In one city, oral sexual activity might be considered a highly risky business; in another, not so much of a concern. Puzzled inquirers felt left in the dark on a crucial issue. Men and women trying to educate and counsel have felt their confidence eroding.

Furthermore, the categories in which sexual activities were discussed have come under critical fire. Various schemes in different regions use classifications based on "risk-safety", "danger-safety", with the added modifications of "high", "low", "medium", and "possibly". What was the real difference, for example, between

"possibly low risk" and "possibly safe"? How could this confusing array of lists be of use in educating people and fostering the practice of safer sex?

The Canadian AIDS Society, a national network of community-based AIDS organizations, was requested by its members to undertake a review of the situation and to consult with competent people both in the field of HIV transmission and in AIDS education. This Report is our contribution to resolving the problems of safer sex guidelines.

The mandate of the Safer Sex Consultation was twofold: first, to undertake a critical investigation of the efficiency of HIV transmission involved in each of the activities in the sexual repertoire, based on available research. Second, to construct a scheme of classification which would clarify the meaning of the risks that were discovered, one that could standardize the present array of often confusing categories.

1.03 Focus And Limits Of The Report

This Report is not a self-sufficient and complete manual for preventive education or counselling. It is addressed primarily to men and women who are engaged in educational and support activities. We hope that it will serve as a resource document upon which the booklets, pamphlets, programs and conversations on safer sex can be based. The multiple factors in some of the sections make it unsuitable for people looking for an answer to a first question.

Safer sex education and counselling are complex and demanding enterprises. No report, however valuable, can remove the challenge of behaviour change from the realities of inter-personal, social and psychological dynamics. Many problems in both education and counselling will certainly remain daunting despite our efforts to achieve consensus and clarity on some aspects of the question.

Our mandate as members of the Safer Sex Consultation was to provide information on safer **sex**. We did not concern ourselves with non-sexual modes of transmission such as IV needle-sharing or blood transfusions. For the same reason, we do not provide a discussion of abstinence. Although it is an option in HIV prevention, it is not a sexual activity.

We have made a conscious choice to use rather formal and even technical language for much of the report. Why? First of all, we needed very specific terms to describe the variations in sexual acts. We wanted to assess each type of sexual practice closely, without confusing it with a similar act. Second, we wanted to emphasize the status of the report as a resource rather than as a ready-made solution. By use of formal language, we do not at all wish to express any opinion about what is "proper". On the contrary, our own educational philosophy requires that a variety of specifically tailored terms be used for the many different needs of people in their own erotic vocabularies.

2.0 Discussing Risk And Safety

2.01 The Idea Of "Risk"

In safer sex discussions, the idea of "risk" occupies a central place. Given the seriousness of HIV infection, people are naturally interested in avoiding it. What proves frustrating to the process of education, however, is that demands for certainty are made upon an idea which is defined precisely in terms of chance and variation.

A risk is a chance of injury, damage or loss. A chance is a possibility. A possibility may or may not occur. There is an emotional and intellectual conflict that surfaces in safer sex education and counselling, and it reflects the strife between a hunger for assurance and the unavoidable residue of unpredictability that acompanies any "risk".

Educators and counsellors must face the anger and confusion which this tension creates. We need to show the link between the risks involved in sexual activity and the risks which permeate daily life. Even in this crisis, HIV infection is not the only realm of risk-taking. The notion that risk only arises in sex is as false as the widely-held assumption that "morality" is entirely concerned with sex. One way of enabling people to make informed choices about sexual activity in the presence of possible HIV infection is to help them to see how many risks they already choose to take.

The opposite of risk is safety, the assurance of well-being. Our best information to date allows us to state that some sexual practices are safe -- that is, they present no danger, no possibility of damage. We can also say that some sexual acts carry such a great risk that we encourage people to avoid them completely. However, a great many common sexual practices are neither problem-free nor always dangerous. And they are not in the middle of a spectrum of risk-safety. Some are safer than others. Educators and counsellors must reflect on the element of indeterminacy which is part of the very idea of "risk", and seek to empower people to take responsibility for their sexual choices.

2.02 Risk Activities And Risk Groups

The notion of **risk groups** came into prominence early in the public discussion of AIDS. The phrase is often a covert term for "homosexual men", especially given the early link between AIDS and gay men in North America. Hemophiliacs, intravenous drug users and other groups are also included in the term "risk group." While there is some usefulness in the term for purposes of epidemiology , it is a destructive and dangerous concept when used in media, education or counselling. First, it may further stigmatize people who already suffer societal exclusion. But it also supports the incorrect notion that HIV infection depends on who you are rather than on what you do. A review of the global epidemiology of HIV infection disproves that idea.

We wish to emphasize that risky **activity** is the important focus in safer sex education. Not only do people outside "risk groups" become infected with HIV, but many people who may engage in sexual activity which permits infection do not identify themselves with any "risk group". For the sake of preventive education, as well as social justice, we want to emphasize that activity is more significant than identity. The important thing is not so much who you are as what you do.

Nevertheless, the requirements of good communication demand that education be targeted. It should be aimed at the needs and interests of the many groups of people who constitute "society". While the use of the term "risk groups" is counterproductive, educational projects should be tailored to target groups -- women, for instance -- who have special questions about HIV. But the most effective educators know that within the broad category "women", different ethnic, sexual, social and age groups need to be addressed. There are many variables which must be taken into account for the various educational target groups. Some of these variables are: literacy levels, ways of speaking, group sexual mores, notions and experience of health care, the politics of personal choice and response to information. To get a message across in a highly message-saturated world, any safer sex campaigns must be specific: addressed to a particular audience in the language and images meaningful to them.

2.03 Theoretical And Practical Risks

Focusing on risk activities places our energy in the right place, but it does not solve some other problems. Information about sexual practices is sometimes based on hard data, and sometimes rests on the application to specific situations of general principles or inconclusive data. Not only does the idea of risk obstruct people's desire for certainty in all the realms of safer sex, but the risks themselves can be practical or they can be theoretical.

As one example, questions often arise about the advisability of kissing, where saliva is often exchanged. It is widely known that HIV has been isolated -- though not often -- from saliva. Because researchers have found that saliva can contain low levels of virus in a small number of HIV infected people, there exists the theoretical risk that transmission can occur. However, no study has been able to show that such a route has in fact allowed infection to happen. Furthermore, other theoretical considerations make it unlikely that saliva is sufficiently hospitable to HIV to act as an efficient medium of infection. When people ask about the risk of wet kissing, the answer appears to be ambiguous. It is based on an imprecise combination of theoretical and practical study.

How people respond to this unavoidable imprecision is itself unpredictable. Educators and counsellors have the task of maintaining the reality of these two kinds of risk in discussions of safer sex. The present state of research does not permit absolute certainty about the risks of certain sexual activities. People's reactions to this situation often mirror their larger patterns of response to uncertainty. Programs must discover and address these patterns. Again, we believe that empowering people to make responsible choices is at the heart of prevention.

3.0 Categorizing Sexual Risk

3.01 Choosing A Model Of Risk

We are conscious of the importance of the **model** which we employ in talking about the sexual repertoire. Doubts about the advisability of continuing to speak of risk, hazard or danger have been voiced in many quarters. Sexuality bears enough negative weight in our culture without reinforcing it through association with danger. The imprecision of the idea of risk continues to stymie hopes for an objective and quantifiable way in which to express degrees of likelihood of HIV transmission. The inability of any model of risk classification to meet the varied needs of different areas of society forces us to admit the limitations of even our best efforts.

A classification scheme by itself has no power at all to induce the life-saving behavioral change that comes from the practice of safer sex. Even the most apparently neutral and general categorization fails to respond to the diversity of human cultures, ages, and modes of communication. The model we have chosen can only serve as a short-hand attempt to organize into a usable form the varied elements of safer sex practices. We offer it as an example, a background resource. It cannot replace the work of translation into the terminology of sex and decision-making by people who understand those with whom they speak.

We have assessed the efficiency of any sexual act in transmitting HIV, based on medical evidence and scientific study. Our model is therefore a frankly medical-scientific one. It is composed of three clusters of activities on a continuum of risk. It is based on the best-designed studies available to us.

3.02 Three Levels Of Risk

We have tried to reduce the role of theoretical risk to a minimum by relying on studies of actual patterns of HIV transmission. Some studies base themselves on a univariate analysis. This means that they only observe a single sexual behaviour without reference to what other activities people might be involved in. For example, a univariate analysis would conclude that if many HIV-infected people had

participated in oral sex, then that activity would be an efficient means of transmission. However, this method of analysis is flawed. It does not take into account the other activities which might promote transmission. Our model of risk is therefore based on several multivariate studies. These assess each sexual activity with the context of the multiple activities which constitute an individual's sexual history. By a careful cross-analysis, these studies provide a much more accurate picture of the relative risks of different types of sexual behaviour.

We have constructed three categories of risk for sexual activity. These categories are based on the combination of theoretical and practical risks of HIV transmission that our present knowledge and data suggest.

No possibility of HIV transmission. To our knowledge, none of the practices in this group have ever been alleged to be a possible route of HIV transmission. In addition, no theoretical risk is present since none of the basic conditions for viral transmission are present.

Minimal-to low possibility of HIV transmission. The practices listed in this category all present a theoretical risk of transmission. They involve exchange of body fluids such as saliva, semen, blood, urine, vaginal secretions, pre-ejaculate, or feces. However, the amounts, conditions and media of exchange are such that the efficiency of HIV transmission is greatly impaired.

If we have **few** reports of infection which appear to be based on one of these activities, we have termed these a low risk behaviour. If the theoretical risk exists but there are **no** reports of infection based on the activity, we consider it only minimally risky.

Sexual activities in the minimal-to-low category are numerous. Questions about their relative risk are frequent and often complex. They involve large amounts of speculation and small amounts of data. It is in this area that sexual politics, personal and social patterns of response to uncertainty, and much discretionary judgement come into play. Advice that may technically mean the same thing can be heard in very different ways. To say, "There is a risk, but it is small," is not quite identical to saying, "Though the risk is small, there is a risk." Our category cannot

overcome that necessary range of nuance in communication. From the present state of our knowledge, however, we believe that this model provides a helpful way of organizing both speculation and data.

Very high possibility of HIV transmission. Intensive and sophisticated study by the best epidemiological methods so often associates these sexual activities with HIV infection that to engage in them makes transmission probable. Even on a theoretical basis, they constitute a clear and present danger because they provide excellent conditions for viral transfer. Even where it is not clear exactly how an activity like unprotected insertive penile intercourse provides highly efficient transmission, studies conclude that this and other sexual activities in this category are very risky.We can summarize the combination of theoretical risk and practical risk which creates these categories as follows:

1. **No possibility of HIV transmission**

Theoretical risk:	none
Evidence of transmission:	none

2. **Minimal possibility of HIV transmission**

Theoretical risk:	yes
Evidence of transmission:	none

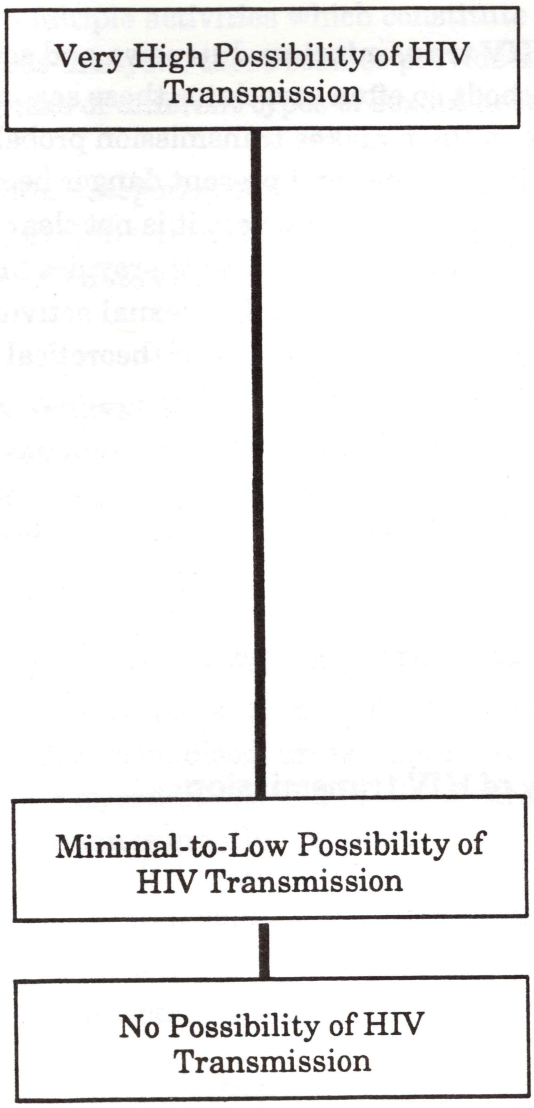
Low possibility of HIV transmission

Theoretical risk:	yes
Evidence of transmission:	small

3. **Very high possibility of HIV transmission**

Theoretical risk:	high
Evidence of transmission:	high

Model Of The Levels Of Risk Involved In Sexual Activities


Very High Possibility of HIV Transmission
Minimal-to-Low Possibility of HIV Transmission
No Possibility of HIV Transmission

This illustration shows the level of risk assigned to any single episode of a sexual activity in relation to other single sexual acts. In considering single kinds of sexual activity, there appeared to be no grounds for speaking of a mid-range risk activity. The routes of high-efficiency HIV transmission are fairly clear. Other routes present

either very low or no possibilities of transmission according to present available evidence.

In order to illustrate the difference between low-to-minimal and very high risk activities, we feel it reasonable to say that if the very high risk sexual activities ceased occurring completely, the rate of new infections would fall so drastically that within a few years HIV would no longer be epidemic.

NO POSSIBILITY OF TRANSMISSION OF HIV

Solo masturbation
Mutual masturbation*
Dry kissing
Body-to-body rubbing (frottage)
Telephone sex
Voyeurism
Erotic films, videos, books, magazines
Fantasy
Exhibitionism
Erotic talk
Body licking and kissing (except mucosal linings)
Massage/touch/caresses
Erotic bathing or showering
Unshared sex toys
Nipple stimulation (without drawing blood)
Nibbling/biting (without blood)
External urination
External defecation
Receptive cunnilingus with barrier
Receptive anilingus with barrier
Insertive anilingus with barrier

*Using semen or vaginal secretions as a lubricant for mutual masturbation is very dangerous. Bringing these fluids into contact with the opening of the partner's penis or the interior of the partner's vaginal area clearly contradicts the principle of preventing contact between possibly infectious fluids and the genital or rectal mucous linings.

MINIMAL-TO-LOW RISK OF TRANSMISSION OF HIV

Minimal possibility of HIV transmission

Wet kissing
Internal urination (ingesting urine)
Anilingus without a barrier
Ingestion of feces
Insertive fellatio without a condom
Insertive fellatio with a condom
Receptive fellatio with a condom
Receptive fellatio without a condom, no ejaculation
Insertive cunnilingus without a barrier outside menstruation
Insertive cunnilingus with a barrier
Receptive cunnilingus without a barrier

Low possibility of HIV transmission

Insertive cunnilingus without a barrier during menstruation
Receptive fellatio without a condom, ejaculation without swallowing
Receptive fellatio without a condom and with swallowing of ejaculate
Insertive penile-vaginal intercourse with a condom
Receptive penile-vaginal intercourse with a condom
Insertive penile-anal intercourse with a condom
Receptive penile-anal intercourse with a condom
Sadomasochistic activity where blood is drawn and proper blood precautions are followed

VERY HIGH POSSIBILITY OF HIV TRANSMISSION

Receptive penile-anal intercourse without a condom
Receptive penile-vaginal intercourse without a condom
Insertive penile-anal intercourse without a condom
Insertive penile-vaginal intercourse without a condom
Coitus interruptus (intercourse with withdrawal before ejaculation) without a condom
Shared sex toys (mutually receptive)

*Manual-anal or manual-vaginal intercourse: see section 4.05

3.03 Ideal No-risk Situations

Much current safer sex education rightly avoids giving the impression that decisions about risk are a simple matter of right and wrong. However, we felt it important to give re-assurance wherever possible so that men and women who follow these guidelines can continue to comply with the suggestions we make, both for the sake of their health and for the sake of their sexual enjoyment.

For this reason, we wish to point out certain situations which, **when achieved**, are ideal no-risk sexual events. They are important parts of the safer sex repertoire and provide a protection from HIV transmission which we feel able to say is complete. These activities contain both theoretical and practical elements of risk except when they occur with precautions that do not fail. If adequate barriers are properly used and proper fluid precautions are observed and in addition, no accident or deviation from procedure takes place, these activities present no risk of HIV transmission:

Category Of Activities With No Risk Of Transmission In An Ideal Situation

Vaginal and anal intercourse, insertive and receptive, with a properly used and effective condom
Fellatio with a properly used and effective condom
Cunnilingus with an effective barrier
Anilingus with an effective barrier

Manual intercourse with a properly used glove (surgical or calving, insertion role only)
S/M activities like piercing, spanking, whipping, etc. which draw blood but in which proper blood precautions have been followed
Digital intercourse with an effective barrier, like a finger-cot

3.04 Co-factors

Exposure to HIV through sexual activity is not the sole factor in transmission of the infection or in the transition from HIV infection to illness. The influence of co-factors has to be taken into account. We understand co-factors in a broad way. They may be **any elements which modify risk** either favourably or unfavourably. An internal co-factor, such as genetic disposition, is not susceptible to personal control. An external cofactor, such as a sexually transmitted disease, can be subjected to personal control. We consider only external co-factors here.

Further, psychological co-factors may have an influence on health, but we limit ourselves to physiological ones.

The external physiological co-factors that concern us have an impact in two ways. They may modify the transmission of the virus from an infected to an uninfected person. They may also influence the transition of an infected person from asymptomatic seropositivity to symptomatic illness. We will specify these concerns when we discuss each sexual activity.

3.04.1 Sexually Transmitted Diseases As Co-factors

Any infection or trauma that enhances the efficiency of HIV transmission is probably a co-factor in the establishment of viral infection in an individual. Syphilis can produce genital, anal or oral ulcers or chancres. Herpes creates open lesions. Gonorrhea irritates the mucosal linings. By altering the membranes in a way which permits greater viral access, all these conditions may increase the chances that HIV will be transmitted. For this reason, certain sexual activities which may not directly transmit HIV can be dangerous by reason of their role in co-factor development.

STDs are a special concern to HIV-antibody positive people. Infections stimulate the immune system. The consequent increased proliferation of lymphocytes can trigger activation of HIV in people who are already HIV-infected. This may result in transition from asymptomatic seropositivity to illness. Hepatitis, Epstein-Barr virus/mononucleosis, herpes, and cytomegalovirus are examples of viruses which may produce this effect (see Section 5.01).

3.04.2 Multiple Partners, Multiple Exposures As Co-factors

Despite the popular notion that having multiple sexual partners is itself contributory to HIV transmission, we feel the need to qualify this idea. Just as we hold that sexual activity is more important than identification with a sexual group, so we consider types of sexual activity more significant than the number of different sexual partners an individual has.

For example, if a couple -- one of whom is seropositive -- are monogamous but engage in unprotected and risky activity, the uninfected partner is in greater statistical danger of infection than an individual who engages in safer sex with many people. What is far more significant than multiple partners is **multiple exposures to infection. Exposure** means that conditions exist such that infection is possible, whether or not it actually occurs. This is primarily a question of specific sexual acts rather than of a variety of partners. Monogamy may be a hedge against infection, but only under very specific circumstances (see section 5.02).

Having said that, number of partners is not without influence in modifying the risk of infection. To have many partners in a population with a high rate of infection may expose an individual to a substantial level of risk, but the nature of the sexual acts is the primary determinant of probability of infection.

Engaging in frequent unsafe sex is more dangerous than infrequent unsafe sex, but a single participation in a high-risk act is sufficient to transmit the virus.

Multiple exposure to the virus certainly raises the odds of infection. But if a person is already HIV-infected, what impact will subsequent exposure have on them? While there is no clear evidence yet to show that further exposure is either harmful

or neutral, two points should be considered. First, any infection stimulates the immune response and such stimulation may increase lymphocyte production. This increases HIV activity. Second, different strains of HIV may produce illness at varying rates or may prefer different systems in the body. Infection with a new strain may cause new problems. Given these possibilities, further exposure to HIV for men and women already infected is not recommended.

Anyone who has had multiple sexual partners should practice safer sex. The greater the compliance with protective guidelines, the less significant the number of partners. Why? Because exposure is reduced. Engaging in minimal-to-low risk activities with many partners has the potential to increase exposure level, but it is riskier to have unprotected sex with a single infected partner than to engage in safer sex with many.

The epidemiology of HIV shows that the incidence of infection varies in different populations. This, too, must be factored into a consideration of the importance of numbers. It is obvious that the likelihood of exposure increases for someone who has several partners in a population where the number of infected individuals is high. Having multiple partners in a population with a low rate of infection is less likely to result in exposure to the virus.

To illustrate, consider the following statistical model for assessing the risks of HIV infection. In a large Canadian urban centre, the rate of infection among gay men might be 20%. If a gay man engages in unprotected anal intercourse twenty times during sexual encounters with one hundred different partners, he runs a 4/10 chance of becoming infected. Compare his situation with another gay man in the same city who engages in the same activity twenty times with his monogomous partner who is infectious. In the second case, the man's chances of becoming HIV-infected are close to 100%. The monogamous man in this situation is 5 times likelier to become infected than the man with many partners. What is crucial to remember is the number of exposures to infection rather than the number of partners. Any discussion of monogamy as a prevention measure must make this clear.

In choosing sexual partners and in deciding whether to practice safer sex, what is most important is an honest and complete assessment of an individual's risk of exposure to HIV. The most important elements in this assessment are sexual

history, participation in needle-sharing or exposure to possibly infected blood. These decisions cannot be based on a person's appearance, attractiveness or manner **[In Bibliography, see J, V]**.

Our model of risk and its three categories are a short-hand way of organizing a great deal of material. It cannot be used without also considering the co-factors involved in a person's real sexual history. For example, we consider receptive fellatio with swallowing of ejaculate a low-risk activity. Empirical multivariate studies indicate this (see section 4.06). However, in educating people to understand the risks involved in their sexual activities or in counselling them about safer sex, the unique co-factors of their situation must be brought into play. Do they live in a place where incidence of infection is high or low? What other kinds of sexual behaviours do they engage in? How many times do they expose themselves to infection? It must be clear that, in the case of oral sexual activity and other minimal-to-low risk activities, the level of risk is different for someone who engages in it twice in comparison with another person who has oral sex dozens of times.

Sex with multiple partners is an issue on which a wide range of social responses can be found. Educators and counsellors must deal with the further complexities of values and beliefs about this phenomenon. However, for the purposes of this report we wish to accentuate the importance of multiple exposures to infection as the most significant co-factor in preventive education.

3.04.3 Alcohol And Drugs

The use of alcohol and recreational drugs can have a significant effect on the decision to participate in high-risk behaviour. The impairment of judgement which these substances can induce reduces the ability to make decisions. It is for this reason that we urge moderation here.

Most drugs, alcohol included, may have an immuno-suppressive effect. This makes them problematic.

To date, despite early suggestions to the contrary, no direct connection has been shown between the use of various drugs (including "poppers") and the development of AIDS in people who are HIV antibody-positive **[B,C,Q]**.

3.04.4 Open Cuts Or Skin Sores

The principles of HIV transmission make it plain that viral access to blood via sores or cuts is possible. Genital sores or herpes chancres, oral cold sores, skin rashes, scrapes or incisions should be protected from contact with blood or semen.

Any sexual activity which could bring blood, semen or vaginal fluid into contact with skin or mucous tissue that is stressed or damaged creates a greater risk of HIV transmission.

3.04.5 Condoms And Protective Barriers

The risks involved in most sexual activity can be greatly modifed by using protective barriers. Although latex has been shown to be impermeable to HIV [Q], misuse or breakage make it impossible to guarantee **in advance** that the use of condoms or other barriers can make any sexual behaviour absolutely safe. It can, however, make it safer.

Latex condoms, when properly and consistently used, greatly improve the safety level of sexual activities. For people who are sexually active, they provide a significant means of reducing the spread of all STDs including HIV. Studies of condom safety and failure in laboratory settings where quality levels are assured yield an average failure rate of 2.3 per 1000 **[G,Q]**. But quality varies depending on source.

The much higher rate of failure of condoms as a pregnancy prevention measure is likely a result of poor or inconsistent usage. In order to achieve the maximum safety of which it is capable, a condom must be used properly and consistently. Care must be taken here, since some safer sex education gives either incomplete or misleading information about condom use **[S]**. Adequate amounts of water-based lubricant are essential.

Most condoms are designed and tested for vaginal intercourse. Their effectiveness ratio for anal intercourse is a matter of dispute. Liberal use of lubricant is

important. A stronger condom would be appropriate, especially one designed specifically for rectal intercourse. Where greater protection is desired, two condoms may be used simultaneously. Breakage of condoms used during fellatio are not a great concern, since breakage then does not pose a significant risk.

Lambskin condoms are inefficient barriers to HIV **[Q]**. However, for people with allergies to latex, a lambskin condom as a second barrier is useful (on top of latex for the receptive partner: underneath for the insertive).

As a protection during cunnilingus or anilingus, other latex barriers such as dental dams have been proposed. Although it lessens sensitivity and is admittedly awkward, the latex dam is effective in preventing viral or bacterial transmission. Alternatives such as plastic wrap are porous to the virus.

Surgical or calving gloves are useful for forms of sexual activity where digital or manual insertion is involved, as well as for mutual masturbation when there are sores or rashes. Finger-cots of latex serve as helpful barriers for digital insertion.

3.04.6 Spermicides And Viricides

Spermicides such as nonoxynol-9 have been shown in laboratory experiments to kill HIV. Their inclusion in condoms for vaginal intercourse is helpful, but since the base of nonoxynol-9 is detergent, it may irritate anal mucosa and should be avoided for rectal sex. Other spermicides and viricides have not been sufficiently tested to warrant a recommendation at this time. We note also that **in vitro** conditions may differ significantly from **in vivo** conditions.

3.05 Education And Risk

While it is not within the scope of the Report to provide a comprehensive program for a safer-sex educational process, we do want to note a few important items:

Any educational use of our model of risk must include not only the triple categories of risk, but also the full range of co-factors we have identified. Otherwise, it can

lead to over-simplifications which become misleading. Few sexual encounters involve only a single behaviour engaged in only once.

Safer sex education and counselling must be seen as an on-going process which cannot be adequately accomplished by a pamphlet and a talk. A model of behaviour change holds that safer sex practice is achieved and maintained best when a person comes to these five beliefs:

1. I am personally threatened by AIDS.
2. I can prevent AIDS.
3. I can manage the necessary behaviour changes.
4. I can still be sexually satisfied.
5. I have peer support for this change.

That is a challenging educational **process** into which our assessment of sexual risk must be factored. The need to be as clear as possible must be linked with the need to recognize the complexities of real sexual life. Many social and psychological co-factors also require intense work. We hope to provide a resource for only a part of the larger effort at creating a new sexual culture. Empowering people to make responsible decisions about their sexual lives is paramount.

4.0 Assessing Sexual Activities

4.01 Principles Of HIV Transmission

The routes of transmission of HIV are well-established: sharing of infected IV needles and syringes, transfusion with infected blood or blood products, perinatal infection and infection through sexual contact. These behaviours create the conditions for transmission of HIV, which needs the following elements in order to occur.

1. There must be a source of infection.
2. There must be a means of transmission.
3. There must be a host organism susceptible to the infection.
4. There must be an appropriate route of entry to the host and its target cells.
5. There must be a sufficient level of organisms delivered to establish infection.

For HIV, the most efficient means of transmission are infected blood, semen and vaginal fluid, when brought into direct contact with the bloodstream or perhaps with certain mucosal cells. Sexual transmission of HIV is not an exception to previously recognized rules of viral transmission. It follows the classic pattern. However, there is an element of unpredictability involved even with these principles. The following assessments of risk are based both on these theoretical patterns and on the increasingly specific evidence from studies of cases of infection.

4.02 Kissing

Dry (no exchange of saliva)	no risk
Wet (with exchange of saliva)	minimal risk

No risk has been alleged or has been shown to be associated with kissing where there is no exchange of saliva [H].

The risks involved with wet kissing* appear to be so minimal as to be insignificant. Saliva may be such a poor medium for the survival of HIV and the virus is found in

such small amounts in so few HIV-infected individuals that only the admixture of blood from a cut or the presence of sores could make this activity a matter of some concern.

The presence of mouth sores, such as herpes simplex, increases the risk of transmission by skin breakage. Contact with these or similar sores should be avoided.

*We avoid the term "French kissing" as inaccurate and "deep kissing" as imprecise.

4.03 Penile-Anal And Penile-Vaginal Intercourse

Penile-anal Intercourse

Insertive, with condom	low risk
Receptive, with condom	low risk
Insertive, without condom	very high risk
Receptive, without condom	very high risk

Penile-vaginal Intercourse

Insertive, with condom	low risk
Receptive, with condom	low risk
Insertive, without condom	very high risk
Receptive, without condom	very high risk

Without the use of condoms, these activities provide maximum ease of transmission for HIV and should be avoided. They provide direct contact of potentially infected semen, blood and/or vaginal secretions with highly-absorbent and easily-traumatized tissue with convenient access to the blood system.

We do not accept the contention of some that the insertive partner is at lesser risk, nor do we believe that vaginal intercourse is an inefficient route of transmission. Presently available studies make it clear that all these forms of intercourse are

associated with high levels of transmission [A,K,L,P,U].The University of Toronto Epidemiology Study shows a very high risk for infection among gay males who restrict themselves to insertive anal intercourse **[B,M]**. African statistics on the number of heterosexual males infected with HIV also indicate the risk for the insertive partner in vaginal intercourse, although the presence of genital sores may be a co-factor **[H,S]**.

Uncircumcised males who engage in insertive intercourse appear to be at greater risk than circumcised males. This may be due to the susceptibility of the foreskin to trauma. Studies on this issue are controversial and a clear answer does not at present exist.

4.04 Digital-Anal And Digital-Vaginal Intercourse

Insertive, with barrier	minimal risk
Receptive, with barrier	minimal risk
Insertive, without barrier	minimal risk
Receptive, without barrier	minimal risk

For the receptive partner, there is no direct risk of HIV transmission unless the inserted finger is cut or abrased. However, what makes this practice problematic is the possibility of trauma to the rectal or vaginal linings. Fingernails can easily tear these membranes, creating a hospitable environment for transmission. Receptive digital intercourse, when followed by unprotected penile insertion -- as is the case for many people -- raises the level of risk considerably.

For the insertive partner, the primary danger comes from contact with small amounts of blood that may find a port of entry in a finger cut. Hangnails may provide an efficient route for all sorts of infection.

Use of a latex glove or a latex finger-cot performs the same protective function as a condom. Any damage to the mucosal membranes, however, raises the risk level for the receptive partner if unprotected penile intercourse follows, even after a lapse of some time.

If a finger is inserted into a partner's vagina or anus, it must not be inserted into another person's vagina or anus without a barrier or a thorough cleaning. Similarly, if a person inserts a finger into his/her own vagina or anus, no insertion in another's is then permissible.

4.05 Manual-Anal And Manual-Vaginal Intercourse

Insertive, with glove	minimal risk
Receptive, with glove	minimal risk
Insertive, without glove	low risk
Receptive, without glove	low risk

The practice of "fisting," inserting the hand or fist into the rectum or vagina, is not by itself an efficient means of HIV transmission. However, studies indicate a high level of correlation between receptive manual intercourse and HIV infection. This is due to the extensive trauma which fisting causes the anal or vaginal canal. If followed by unprotected penile insertion or the use of shared sex toys, fisting results in a very favourable environment for viral transmission. This is so even after a single episode. The trauma to the mucous lining may last for several weeks after the event **[A,B,P,T]**.

For this reason, the risk is greater for the receptive partner. The insertive partner may have cuts or abrasions (including hangnails) and so should use a latex glove.

Our remarks on fisting indicate an important point about these guidelines as a whole. We can only describe the risks of sexual activities by taking them **singly**, but it is rare for people to engage in only one sexual activity. Hence, judgements about their relative risks require a knowledge of both the individual act under examination at the moment and the other activities which comprise its context. **By itself**, fisting is not an efficient route of HIV transmission. But the conditions it creates in the anal/vaginal canal require very careful attention to **other** sexual activities which may accompany or follow it.

4.06 Fellatio

Insertive, with condom	minimal risk
Receptive, with condom	minimal risk
Insertive, without condom	minimal risk
Receptive, without condom (no ejaculation)	minimal risk
Receptive, without condom (no ingestion of ejaculate)	low risk
Receptive, without condom (ejaculate ingested)	low risk

All the variations associated with fellatio can be regarded as minimal-to-low risk activities **[A,M,P,T,U]**. Despite the theoretical risk involved in ingesting a potentially infectious seminal fluid, no well-designed studies have yet shown elevated risk for these behaviours. Fellatio has not been demonstrated to have more than a very small relationship to seroconversion, but because there is some risk, we have placed it in our second category. We note again the limitations of our process of assessment and the importance of co-factors in gauging actual risk to any individual.

Cuts or sores in the mouth (whether they be from trauma, illness or dental procedures) or on the penis or penile opening increase risk.

Significant correlations between fellatio and HIV infection only appear in some early North American studies that are methodologically flawed. They make a univariate analysis, ignoring other sexual behaviours (e.g. unprotected anal intercourse) which are highly effective means of HIV transmission **[E,O,H]**. We have personal communications indicating receptive fellatio as a likely source of infection in less than half a dozen cases. Such reports involve unusual circumstances such as recent tooth extractions or swallowing semen from hundreds of partners.

It is not clear why ingestion of ejaculate is such an inefficient means of transmission, but multivariate studies to date show no significant relationship between fellatio and HIV infection **[B,C]**.

4.07 Cunnilingus

Insertive, with barrier	minimal risk
Receptive, with barrier	no risk
Receptive, without barrier	minimal risk
Insertive, without barrier (outside menses)	minimal risk
Insertive, without barrier (in menses)	low risk

Since cunnilingus in heterosexual relations seldom occurs without penile-vaginal or penile-anal intercourse, assessment of risk is based upon reports of female-female sexual activity. From these only one case of alleged oral-vaginal transmission of HIV exists. Even if this is accurate, it still points to an extremely low index for cunnilingus [C,N].

On a theoretical basis, the insertive partner's risk may be greater than the receptive partner's because of ingestion of vaginal fluids, especially when menstrual blood may be present. Present evidence for oral-vaginal transmission for lesbian women without any other high-risk behaviour (eg, IV drug use) is extremely limited.

4.08 Anilingus

Insertive, with barrier	no risk
Receptive, with barrier	no risk
Insertive, without barrier	minimal risk
Receptive, without barrier	minimal risk

Anilingus is not an effective means of HIV transmission. Contact between saliva and the rectal lining provides a theoretical route, but the low levels of virus in

saliva make such an occurrence unlikely. The risk of HIV infection is therefore minimal **[A,B,C,P,T]**.

However, anilingus is a highly efficient route of transmission for other STDs, including syphilis, hepatitis and intestinal parasites, including cryptosporidium. These are potential co-factors for the development of AIDS in HIV-infected people and their occurrence may favour the triggering of viral growth.

4.09 Urine

External urination	no risk
Internal urination	minimal risk

In terms of HIV transmission, urine poses little threat. It is not an efficient medium for viral growth and contains few of the lymphocytes that host HIV. External urination on unbroken skin poses no possibility of transmission. Ingesting or otherwise allowing urine inside the body does not carry a risk of HIV transmission, but does pose the possibility of infection by other organisms [C].

4.10 Feces

External defecation	no risk
Internal defecation	minimal risk

Although no one has reported the isolation of HIV from fecal material, the occasional presence of blood in waste material makes the presence of virus possible. The risks are similar to anilingus but somewhat greater [C].

Defecation on unbroken skin is not risky. Oral contact with feces is an efficient means for transmission of other infections diseases that appear to hasten development of disease in HIV-infected persons: syphilis, hepatitis and parasites.

4.11 Insertive Sexual Devices

Receptive, shared	very high risk
Receptive, unshared or sterile	minimal risk

Dildoes, vibrators, butt plugs, etc. pose a problem in HIV prevention in two ways. First, depending on their size and use, they cause varying degrees of trauma to the mucosal lining of the anus or vagina. While not directly transmitting HIV, such trauma promotes the possibility of later transmission by making blood more accessible. Second, transferring a sexual device from one partner to another without thorough and effective cleaning allows for sharing of infected fluids. In the first case, sexual toys may promote conditions which permit infection; in the second, they can transmit HIV directly and efficiently **[A,B,C,P,T]**.

4.12 Douching And Enemas

Although the practice of rinsing the rectum or vagina with some liquid appears to foster cleanliness, it is dangerous. Douches and enemas easily irritate the mucosal lining, removing the protective top layer of tissue. If followed by unprotected intercourse, this apparently helpful behaviour creates an environment hospitable to HIV transmission **[A,B,P]**.

4.13 Sadomasochistic Activities

The general principles of HIV transmission are applicable here. Infection takes place when infected blood, semen or vaginal fluid comes in contact with a receptive site: anorectal or vaginal mucosa, an opening to the blood system.

Many S/M activities have always been relatively safe in terms of HIV transmission. It is important, however, that any toys, devices or other gear either remained unshared or be carefully cleaned.

When S/M activities involve the drawing of blood, risk will be lowered by following blood precautions, namely prevention of exchange of blood and avoidance of blood

on the partner's body. Any open cuts should be protected from infection by semen, etc. Severe spanking, whipping, or nipple play, for example, may require such precautions. Piercing and tattooing are likewise activities which call for sterile precautions.

Even when S/M activities are very rough, if they do not draw blood, do not break the skin, and do not include any of the other activities we have assessed as very risky, then they are not a matter of importance as far as HIV transmission is concerned.

5.0 Special Situations

There are two further situations which require attention: the sexual options open to people who are antibody positive, whether they be asymptomatic or diagnosed with AIDS; and the options of the monogamous couple.

5.01 Persons Who Are Antibody Positive, People With HIV-Related Conditions, And People With AIDS

In keeping with our contention that sexual activity is more important than sexual identity, we have no hesitation in stating that these guidelines apply equally to persons who may be sero-positive and to persons who are not. There is no medical reason why antibody-positive persons, persons with some HIV-related conditions or persons with AIDS should abstain from sexual expression. We therefore propose no special guidelines for these men and women other than the ones we have recommended for **all** people at risk. The only special concern we have is the possibility that other STD's may be a factor in hastening the onset of illness in HIV-infected people. **We therefore encourage anyone who is antibody positive or experiencing any HIV-related symptoms to take special care to avoid infection with STD's (see section 3.04.1).**

People with AIDS **may** be more infectious than asymptomatic sero-positive people, but if the guidelines are followed as we intend, with careful adjustment for every individual case, we feel there is no ethical imperative at all for them to forego safer sexual activity. Recognizing the complex emotional factors surrounding such a recommendation, we urge sympathetic and intelligent counselling, so that people may be empowered to make responsible and life-affirming decisions about their sexuality.

5.02 Monogamous Couples

Persons in a monogamous relationship require special attention. Their situation **may** allow them to depart from safer sex practices **within** their relationship. In order to facilitate such a decision, we offer the following principles:

Monogamous couples are sexually exclusive. We define sexual exclusivity to mean that, with the exception of no-risk behaviour, all sexual activity is confined to the two persons in the couple. This definition is based on the possibility of exposure to infection.

We recognise three situations in which couples who are sexually exclusive according to this definition can be considered monogamous.

1. Both parties have had no sexual interaction with anyone prior to their relationship with each other, neither of them has been exposed to HIV through blood transfusions or needle-sharing, and they have maintained complete sexual exclusivity with each other since the beginning of their relationship.

2. Both parties have maintained sexual exclusivity with each other for at least six months, have practiced safer sex for six months, neither of them has been exposed to HIV during that time through blood transfusions or needle-sharing with third parties and after at least six months both of them have received negative results on their HIV antibody tests.

3. Both parties have maintained sexual exclusivity with each other since 1977 and neither of them has been exposed to HIV through blood transfusions or needle-sharing.

Only if a couple fulfills the complete requirements for one of these three situations do we consider them monogamous for the purposes of these guidelines. If any member of a couple has engaged in behaviours which contravene **any** of the conditions, the exceptions to safer sex guidelines which we discuss do not apply to either of them.

For monogamous couples as we define them, there is the option of ceasing the practice of safer sex. If they are sufficiently certain that neither of them is infectious, they may decide to lay aside HIV precautions within their relationship. We urge, however, that this decision take place with good counselling.

Status as a monogamous couple depends on honesty and memory. Both parties must trust that their partner is giving an accurate account of his/her sexual and risk-behaviour history and that their sincerity is matched by a reliable recollection of that history. In the case of two virgins or two long-time partners (as defined above), HIV testing and counselling is an option for justifying their non-infectious status. For a recently monogamous couple, such testing and counselling is a necessity.

Given the enormous psychological and social risks involved in HIV testing, we again urge serious counselling **before** and **after** testing. Given the possibility of indeterminate confirmatory HIV antibody test results in populations where HIV infection is low, such testing may only be useful to gay men, where indeterminate test results are extremely uncommon.

We wish to emphasize that the use of periodic testing as an alternative to the practice of safer sex is dangerous and irresponsible.

If one member of a monogamous couple is seronegative and the other seropositive, they must continue to follow all safer sex guidelines. As we mentioned, unsafe sex in such a relationship is more dangerous than unsafe sex with several partners (not all of whom may be seropositive, see section 3.04.2). If one member's antibody status is known (be it positive or negative) and the other's is not, prudence requires that safer sex continue to be the rule. If neither member of the couple knows their antibody status but either one has engaged in behaviour that would expose them to any level of risk, we again urge the practice of safer sex.

If both partners have tested negative under the conditions we mentioned earlier, they may decide not to practise safer sex, without risk of HIV transmission. If some risk activity should occur outside the relationship, they would have to return to strict exclusivity with safer sex practices for another six months and be re-tested.

If both partners test positive, what are their options? Research to date has not been able to demonstrate a link between repeated exposure to HIV and progress to illness. The general principle that any stimulation of the immune response may trigger activation of dormant HIV, however, suggests that unsafe sex here is not advisable. Furthermore, different strains of HIV may cause disease at different rates. The organs and systems affected may also vary with different strains. Since

re-infection with a different strain may produce new health problems, we advise the practice of safer sex when both partners are antibody positive.

Monogamous couples who do not know their antibody status and who have not been practicing safer sex should, on this line of reasoning, be encouraged to consider undertaking these guidelines. There is no compelling medical evidence at present in either direction.

In regard to practices such as anilingus or sexual acts involving feces, if both members of an exclusive couple are free of parasites and are known not to be infected by hepatitis, then these behaviours are an option for them.

It should be apparent that the situation of sexually exclusive couples is complex. We offer these reflections as a resource for the process of counselling which we believe must accompany any decision to depart from the norms of safer sex. We urge educators to exercise great care in transmitting such information so that people are not misled into thinking that, simply because they consider themselves "monogamous", they truly are.

6.0 Appendices

6.01 Appendix One: A Glossary Of Formal And Popular Terms For Sexual Activity

Masturbation:	Jacking off, jerking off, J/O
External/Internal Urination:	Watersports, golden showers
External/Internal Defecation:	Scat
Fellatio (receptive):	Giving head, giving a blow job, sucking, cock-sucking, blowing, French active
Fellatio (insertive):	Getting a blow job, getting blown, face-fucking, French passive
Cunnilingus:	Eating out, licking, going down
Intercourse (anal/vaginal):	Fucking
Insertive:	Fucking, screwing, laying, Greek active (anal only)
Receptive:	Getting fucked, screwed, laid, Greek passive (anal only)
Digital Intercourse:	Fingering, finger job
Anilingus (insertive/receptive):	Rimming, getting rimmed
Manual Intercourse:	Fisting, getting fisted
Pre-ejaculate Fluid:	Pre-cum
Ejaculate:	Cum, jism, cream, wad, load
Penis:	Cock, dick, prick, stick, rod
Anus:	Asshole, hole
Sexual Devices:	Sex toys
Vagina:	Pussy, box, lips, cunt

6.02 Appendix Two: Summary Of Sexual Activities Assessed For HIV Transmission Risk Factors

Penile-vaginal Intercourse

Insertive, with condom	low
Insertive, without condom	high
Receptive, with condom	low
Receptive, without condom	high

Penile-anal Intercourse

Insertive, with condom	low
Insertive, without condom	high
Receptive, with condom	low
Receptive, without condom	high

Digital-anal/Digital-vaginal Intercourse

Insertive, with barrier	minimal
Insertive, without barrier	minimal
Receptive, with barrier	minimal
Receptive, without barrier	minimal

Manual-anal/Manual-vaginal Intercourse

Insertive, with glove	minimal
Insertive, without glove	low
Receptive, with glove	minimal
Receptive, without glove	low

Fellatio

Insertive, with condom	minimal
Insertive, without condom	minimal
Receptive, with condom	minimal
Receptive, without condom (no ejaculation)	minimal
Receptive, without condom (ejaculate ingested)	low
Receptive, without condom (no ingestion of ejaculate)	low

Cunnilingus

Insertive, with barrier	minimal
Insertive, without barrier (outside menses)	minimal
Insertive, without barrier (in menses)	low
Receptive, with barrier	no
Receptive, without barrier	minimal

Anilingus

Insertive, with barrier	no
Insertive, without barrier	minimal
Receptive, with barrier	no
Receptive, without barrier	minimal

Kissing

Dry (no exchange of saliva)	no
Wet (with exchange of saliva)	minimal

Urination

External urination	no
Internal urination	minimal

Defecation

External defecation	no
Internal defecation	minimal

Insertive Devices

Receptive, shared	high
Receptive, unshared or sterile	minimal
Insertive, with barrier	minimal
Insertive, with glove	minimal

7.0 Bibliography

Please note that the reference letters for each entry refer to their usage within the text of the Safer Sex Guidelines.

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CANADIAN AIDS SOCIETY

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Safer Sex Guidelines:

A Resource Document For Educators and Counsellors

* produced by the Canadian AIDS Society (a national coalition of community-based organizations)
* based on the most up-to-date and reliable clinical studies of patterns of HIV transmission
* contains a thorough discussion of risks and co-factors in sexual transmission of HIV
* assesses the risks of each sexual activity and gives the reason why
* lists useful articles and studies for further research
* updated yearly
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